CASEREVIEW

8017 Sitka Street
Fort Worth, TX 76137
Phone: 817-226-6328
Fax: 817-612-6558

Notice of Independent Review Decision

[Date notice sent to all parties]: January 22, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
C6-7 Transforaminal ESI

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
This physician is Board Certified in Anesthesiology with experience in Pain Management for over 6 years.

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a female who was injured on xx/xx/xx. Mechanism of injury was not provided.

On October 29, 2014, MRI Cervical Spine, Impression: 1. ACDF C4 through C6. 2. Degenerative disc disease worse above and below the fused levels C3-4 and C6-7 where there is moderate central canal stenosis.

On December 5, 2014, the claimant presented with complaints of bilateral shoulder pain, cervical spine pain and lower back pain radiating down bilateral lower extremities. The cervical spine pain was described as aching, sharp, shooting, stabbing, throbbing and tightness that is constant and rated 6/10. Triggers include walking, with exercise and with any activity. Pain improves with stopping activity, when heat is applied, with lying down, with position change and

with rest. Associated symptoms include headache, stiffness and weakness. Previous therapies include physical therapy with minimal relief and blocks where pain relief was moderate. Current Medications: Cefpodoxime 200 mg tablet. It was noted that the claimant received 75-80% low back pain relief from her injection at bilateral L4-5 foramina. On examination of the cervical spine ROM was decreased and there was tenderness at the bilateral paravertebral from C3 through C7. Plan: Degenerative disc disease worse above and below the fused levels C3-4 and C6-7 where there is moderate central canal stenosis. Schedule her for a C6-7 TLESI for pain control. 2 week follow up s/p ESI to document pain relief.

On December 17, 2014, UR. Rationale for Denial: Per medical records the claimant has chronic pain, and is status post ACDF with degenerative disc disease, and has had a previous block in which she received moderate relief. The MRI of the cervical spine dated 10/29/14, while t did show moderate central canal stenosis, with an annular bulge, there was no impingement on the spinal cord. In addition, the current medical documentation however, has insufficient objective physical exam findings consistent with radiculopathy. Per ODG< "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, there is no documentation as to when the previous block was given or objective functional benefits such as decreased VAS scores to show at least 50% decrease in pain relief. Therefore, the request for a C6-7 Transforaminal ESI is not medically necessary and thus not certified.

On December 26, 2014, UR. Rationale for Denial: ODG states, Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). There are no red flags and/or significant positive objective findings specifically radicular complaints/signs that are corroborated by MRI and/or EMG/NCV findings to support request. Also, there is no documentation that claimant has failed adequate trial of conservative care.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:
The previous adverse determinations are upheld. Claimant does not have any significant positive objective findings of radiculopathy either by MRI or EMG/NCV. Per ODG, there must be documented radiculopathy to support ESI. Additionally, per ODG, there must be documentation that the claimant has failed conservative therapy. There is no such documentation in the provided records. Therefore this request for C6-7 Transforaminal ESI is non-certified.

PER ODG:

Criteria for the use of Epidural steroid injections:

Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.

(1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing.

(2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).

(3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance.

(4) *Diagnostic Phase:* At the time of initial use of an ESI (formally referred to as the "diagnostic phase" as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections.

(5) No more than two nerve root levels should be injected using transforaminal blocks.

(6) No more than one interlaminar level should be injected at one session.

(7) *Therapeutic phase:* If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the "therapeutic phase." Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007)

(8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response.

(9) Current research does not support a routine use of a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment.

(10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment.

(11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.)

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**